1. CORPORATE INFORMATION

WellPoint, Inc. (WellPoint) State Sponsored Business' corporate information is as follows:

Name: WellPoint, Inc. State Sponsored Business
Address: 5151-A Camino Ruiz, Camarillo, California 93012
Phone: (805) 384-3348
Fax: (805) 384-3630
E-Mail: Randy.S.Thomas@WellPoint.com

2. PARENT ORGANIZATION INFORMATION

The parent organization information of WellPoint State Sponsored Business is as follows:

Name: WellPoint, Inc.
Address: 120 Monument Circle, Indianapolis, Indiana 46204
Phone: (317) 488-6169
Fax: (317) 488-6863
E-Mail: Nancy.Purcell@WellPoint.com

3. STATE OF INCORPORATION

WellPoint, Inc.'s state of incorporation is Indiana.

4. STATES WHERE WELLPOINT IS LICENSED TO DO BUSINESS

WellPoint State Sponsored Business is licensed and currently doing business in the following states, identified below.

In California, we are licensed by county as various plan types – either as a Health Maintenance Organization, Preferred Provider Organization, or Exclusive Provider Organization through a flexible Knox-Keene Act license.

Table 4-1: States Where WellPoint State Sponsored Business is Licensed for Business

Client	Program	Certificate of Authority
California		
California Department of Health Services	Medi-Cal — Medicaid Managed Care	HMO
LACare	Medi-Cal — Medicaid Managed Care	HMO
California Managed Risk Medical Insurance Board (MRMIB)	Healthy Families Program (SCHIP)	HMO, EPO
California MRMIB	Major Risk Medical Insurance Program (MRMIP)	PPO, EPO
California MRMIB	Access for Infants and Mothers (AIM)	HMO, PPO, EPO
California Kids Healthcare Foundation	California Kids	HMO
Governing Body of the County Medical Services Program	County Medical Services Program	PPO, EPO
Virginia		
Virginia Department of Medical Assistance (DMAS)	Medallion II — Medicaid Managed Care	HMO
Virginia DMAS	FAMIS (SCHIP)	HMO
West Virginia		
West Virginia Bureau for Medical Services (BMS)	Medicaid Managed Care	HMO
Texas (Starting in 2006)		
Texas Health & Human Services Commission	Medicaid Managed Care	HMO
Nevada (Starting in 2006)		
Nevada Division of Health Care Financing and Policy	Medicaid Managed Care	HMO

5. CONTACT INFORMATION

We provide the following WellPoint State Sponsored Business contact information to the Bureau of TennCare:

Name: Randy S. Thomas
Title: Director, Business Development, WellPoint State Sponsored Business
Phone: (805) 384-3348
Fax: (805) 384-3630
E-Mail: Randy.S.Thomas@WellPoint.com

6. PROGRAM EXPERIENCE — GENERAL

State Sponsored Business, the Medicaid-dedicated unit of WellPoint, Inc., is the nation's largest provider of Medicaid and other publicly funded services. Most of our Medicaid experience is capitation-based. We also believe in the value of being NCQA-accredited and we actively pursue NCQA accreditation for each of our programs as quickly as possible.

A. MEDICAID AND CAPITATION EXPERIENCE

WellPoint State Sponsored Business has almost a dozen years of capitation experience with Medicaid, SCHIP, and other publicly funded programs. We entered the Medicaid market in 1994, in response to the industry's growing need for managed care. Table 6-1 identifies the states, clients, and contract periods for each of our Medicaid, SCHIP, and other publicly funded programs.

Table 6-1: WellPoint State Sponsored Business Capitation Contracts

State	Client / Program	Contract Period
California	Department of Health Services / Medi-Cal (Medicaid Managed Care)	1994 to ongoing
California	LACare / Medi-Cal (Medicaid Managed Care)	1997 to ongoing
California	Managed Care Risk Medical Insurance Board (MRMIB) / Healthy Families (SCHIP) Program	1998 to ongoing
California	MRMIB / Major Risk Medical Insurance Program (MRMIP)	1991 to ongoing
California	MRMIB / Access for Infants and Mothers (AIM)	1992 to ongoing
California	County Medical Services Program Governing Board / County Medical Services Program	2005 to ongoing
Virginia	Department of Medical Assistance (DMAS) / Medallion II Medicaid Managed Care	2001 to ongoing
Virginia	DMAS / FAMIS (SCHIP)	2001 to ongoing
West Virginia	Bureau for Medical Services (BMS) / Medicaid Managed Care	2003 to ongoing
Texas	Health and Human Services Commission (HHSC) / STAR Medicaid Managed Care and the Children's Health Insurance Program (SCHIP)	"Go Live" in September 2006. Contract signed November 2005.
Nevada	Medicaid Managed Care and Nevada Check-Up (SCHIP)	"Go Live" in July 2006. Contract under negotiation.

In addition to the programs identified above, WellPoint, through our traditional lines of business, operates Medicaid and other publicly funded programs in the states of Connecticut, Colorado, Massachusetts – Administrative Services Only (ASO), Wisconsin, and the Commonwealth of Puerto Rico.

B. MEDICAID NCQA ACCREDITATION

WellPoint State Sponsored Business understands the importance of the NCQA accreditation. We currently hold an NCQA "Excellent" accreditation for our Medicaid health plan in the state of California. We are the only health plan in California to hold the highest designation that NCQA bestows upon accredited Medicaid health plans. We have held this designation since 2003.

In Virginia, we received the Medicaid New Health Plan designation within three years of starting operations in that state. We are committed to achieving the Medicaid New Health Plan designation as quickly as possible in every state where we provide services. We are awaiting NCQA New Health Plan accreditation for our new West Virginia program at this time. We will be working to achieve the Medicaid New Health Plan designation in Texas and Nevada and we will proceed to receive the designation as quickly as possible in Tennessee as well.

Because we are a NCQA-accredited organization, we have extensive experience with HEDIS® and CAHPS® measurements. Many of our interventions, monitoring and benchmarks are HEDIS based. We include the results of the most recently conducted CAHPS surveys in our annual Comprehensive Analysis.

C. MEDICAID CONTRACTS CURRENTLY IN PLACE

State Sponsored Business and its parent company, WellPoint, Inc. currently contracts with the states of California, Connecticut, Massachusetts, Virginia, West Virginia, Wisconsin, and the Commonwealth of Puerto Rico to provide Medicaid and other publicly funded services to eligible members. In 2006, we will begin providing Medicaid services in Texas and Nevada.

7. MEDICAID PROGRAM EXPERIENCE — SERVICES

Table 7-1 is provided to show our current Medicaid and SCHIP contracting experience. If we currently provide the service, the notation shows either "D" to indicate we provide the service directly, or "S" to indicate a subcontract arrangement for the service. Otherwise, the service is carved-out of the program.

Table 7-1: Current Medicaid/SCHIP Program Experience by State

Service	California	Virginia	West Virginia	Texas	Nevada
				Starting in 2006	
a. Physical Health Benefits	D	D	D	D	D
b. Dental Benefits		S		S	D
c. Vision Benefits	S	S	S	S	D
d. Non-Emergency Transportation		S			
e. Behavioral Health Benefits		S		S (SCHIP)	S
f. Pharmacy Benefits	D	D		D	D
g. Long-Term Care benefits (nursing facility and home and community-based waiver services)					
h. Home Health	D	D	D		D
i. Claims Processing and Adjudication	D	D	D	D	D
j. Quality Assurance	D	D	D	D	D
k. Utilization Management	D	D	D	D	D
l. Case Management	D	D	D	D	D
m. Disease Management	D	D	D	D	D

Service	California	Virginia	West Virginia	Texas	Nevada
				Starting in 2006	
n. Provider Credentialing	D	D	D	D	D
o. Enrollment Assistance	D (SCHIP)				
p. Member Services (inquiry, ID cards)	D	D	D	D	D
q. Member Grievances/Appeals	D	D	D	D	D

8. MEDICAID PROGRAM EXPERIENCE — POPULATION

Table 8-1 is provided to show our current contracting experience by populations served. The table includes the approximate number of individuals served in each population. Note that we do not count dual eligibles separately. Also, the Seriously Emotionally Disturbed Children/Youth (SED) number for California SCHIP is the number of SED children and adolescents identified by individual counties as meeting the state's program criteria for SEDs.

Table 8-1: Current Program Population Experience by State

Service	California	Virginia	West Virginia	Massachusetts (ASO)
Aged, Blind and Disabled (including dual eligibles)	38,049	4,036	-	-
TANF and TANF-Related	827,145	43,802	66,812	-
SCHIP	294,386	10,180	-	-
Waiver Expansion Population (low-income uninsured)	58,963	-	-	34,967
SPMI (Seriously and Persistently Mentally Ill)	Carved-out	Not available	Carved-out	-
SED (Seriously Emotionally Disturbed Children/Youth)	558 (SCHIP)	Not available	Carved-out	-

9. MEDICAID PROGRAM EXPERIENCE — PAYMENT METHODOLOGY

The following table indicates the payment methodology for each of WellPoint State Sponsored Business' contracts and the financial incentives and measures, where applicable.

Table 9-1: Payment Methodology and Financial Incentives by Client and Program

Client	Program	Risk Arrangement	Performance Incentive
California			
California Department of Health Services	Medi-Cal – Medicaid Managed Care	Full Risk	Beginning in 2006, preferential auto-assignment will be based on HEDIS measures.
LACare	Medi-Cal – Medicaid Managed Care	Full Risk	Beginning in 2006, preferential auto-assignment will be based on HEDIS measures.
California Managed Risk Medical Insurance Board (MRMIB)	Healthy Families Program (SCHIP)	Full Risk	
California MRMIB	Major Risk Medical Insurance Program (MRMIP)	2 contracts: One as ASO for the entire program; the second as a provider of benefits with a Refunding Agreement	
California MRMIB	Access for Infants and Mothers (AIM)	Full Risk	
California Kids Healthcare	California Kids	Refunding Agreement	
Governing Board of the County Medical Services Program	County Medical Services Program	ASO contract with performance incentive	Administrative fee is guaranteed not to exceed the program's current expenditure. A savings-sharing agreement has been established to share in program savings over established baselines.
Virginia			
Virginia Department of Medical Assistance (DMAS)	Medallion II Medicaid Managed Care	Full Risk	
Virginia DMAS	FAMIS (SCHIP)	Full Risk	
West Virginia			
West Virginia Bureau for Medical Services (BMS)	Medicaid Managed Care	Full Risk	
Texas (Starting in 2006)			
Texas Health & Human Services Commission	Medicaid Managed Care	Full Risk	Three performance goals including network adequacy and access to care, access to behavioral health service, and a third to be negotiated with HHSC.
Nevada (Starting in 2006)			
Nevada Division of Health Care Financing and Policy	Medicaid Managed Care	Full Risk	

10. MEDICAID PROGRAM EXPERIENCE — FORMER MEDICAID AND/OR COMMERCIAL

WellPoint State Sponsored Business currently provides Medicaid services in the states of California, Massachusetts, Virginia, and West Virginia. Because we have identified several current programs in these and other states, we are not providing former Medicaid or commercial contracts as examples of our experience.

11. REFORMED MANAGED CARE MODEL

WellPoint State Sponsored Business is well versed in capitated-managed care that spans a full spectrum of services for its members. Our programs, in addition to physical health, often include behavioral health, dental, vision, and pharmaceutical coverage. We have developed expertise in managing and coordinating care for our members to provide the maximum benefit possible while still containing costs.

A. BEHAVIORAL HEALTH

WellPoint State Sponsored Business understands the importance that the state of Tennessee is placing on the coordination of care between behavioral health and physical health services. As the primary contractor for all of our programs, we have experience fully managing and coordinating services to treat members' conditions on a daily basis.

1. States and Populations Served

WellPoint State Sponsored Business currently offers behavioral health as a carve-in service to several of its Medicaid managed care and other publicly funded programs. Depending upon the population, we use our in-house experts or contract with a behavioral health subcontractor.

Program: California State Children's Health Insurance (SCHIP)	
Description of behavioral health services: WellPoint State Sponsored Business has been using our in-house expert WellPoint Behavior Health, Inc. (WBH) to provide capitated behavioral health services since 1999. WBH is the largest behavioral health provider for California's SCHIP program. WBH emphasizes utilization review of all levels of facility-based behavioral health care including inpatient hospitalization, partial hospital programming, and intensive outpatient programming. WBH also provides utilization review when a member receives outpatient services within a behavioral health professional's offices after the first visit that results from a self-referral to an in-network provider. In addition, WBH's care managers conduct SED screenings, based on the state's criteria under which children and adolescents may be referred to the Department of Mental Health Community Center for assessment as SED.	
Total Population: 294,000	**Serve SED / SPMI:** Yes
Services provided by subcontract?: No	
Description of subcontract arrangement / coordination of care across entities: N/A	
Description of subcontractor payment: N/A	

Program: California Medicaid (Medi-Cal)	
Description of behavioral health services: While behavioral health is not included in the Medi-Cal Managed Care benefit package, WellPoint State Sponsored Business has coordinated services with behavioral health providers to ensure continuity of care across the board among physical and behavioral health providers. As part of these activities, we have executed memoranda of understanding with county mental health departments and Community Mental Health Centers (CMHCs).	
Total Population: N/A	**Serve SED / SPMI:** N/A
Services provided by subcontract?: N/A	
Description of subcontract arrangement / coordination of care across entities: N/A	
Description of subcontractor payment: N/A	

Program: Virginia Medicaid Medallion II Managed Care	
Description of behavioral health services: WellPoint State Sponsored Business manages both mental health and substance abuse benefits under a comprehensive physical/behavioral health contract with the Virginia Medallion II Medicaid Managed Care program, which includes mandatory enrollment of the aged, blind, and disabled (ABD) population.	
Total Population: 59,000	**Serve SED / SPMI:** Yes
Services provided by subcontract?: We use a behavioral health subcontractor, Magellan Health Services, which is responsible for the full range of behavioral health organization activities, including network development and management, customer service, claims processing, utilization management, quality assurance, and care coordination (care management). The behavioral health network provides for the delivery of inpatient and outpatient mental health and substance abuse benefits. The networks include CMHCs and other traditional mental health providers, as well as detoxification centers and other substance abuse providers.	
Description of subcontract arrangement / coordination of care across entities: Magellan has biweekly clinical calls, quarterly collaboration calls, and attends the Quarterly Provider Quality Review Committee meetings with our staff and primary care providers (PCP). These meetings facilitate collaboration between Magellan and WellPoint State Sponsored Business by ensuring both clinical teams are aware of ongoing initiatives and members who require assistance from both organizations.	
Description of subcontractor payment: Our contract with Magellan is a capitated per member per month arrangement.	

Program: West Virginia Medicaid Managed Care	
Description of behavioral health services: Our network PCPs must coordinate behavioral health services, as appropriate, with the fee-for-service (FFS) providers. Our network PCPs practice to the full level of their professional competency in the area of behavioral health (e.g., treatment for anxiety and other affective disorders including mild to moderate depression, psychosis, dementia, and delirium). When a PCP is unable to manage a case, then the PCP makes a referral to the behavioral health provider and serves as our point of contact. In an urgent or emergent medical situation, we are responsible for stabilizing the patient and making a referral to the behavioral health provider.	
Total Population: 67,000	**Serve SED / SPMI:** N/A
Services provided by subcontract?: No	
Description of subcontract arrangement / coordination of care across entities: N/A	
Description of subcontractor payment: All behavioral health services, with the exception of services provided to children under the age of three, are provided on a FFS basis.	

Program: Texas STAR Medicaid Managed Care and SCHIP	
Description of behavioral health services: The state of Texas recently awarded WellPoint State Sponsored Business a contract to serve SCHIP members beginning in September 2006. WellPoint will also serve Medicaid Managed Care members through the STAR program and the SCHIP members for physical health benefits.	
Total Population: 15,000 (anticipated enrollment for the first calendar year)	**Serve SED / SPMI:** Yes
Services provided by subcontract? For this contract, we have partnered with Magellan of Texas for the delivery of behavioral health services for the SCHIP program only.	
Description of subcontract arrangement / coordination of care across entities: Magellan has implemented standard procedures relating to coordination of behavioral health and physical health services. Care coordination will be a two-way process. Behavioral health providers will be trained to identify physical health problems and make an appropriate referral to the primary care network. During PCP training, care coordination will be reinforced to enable the PCP to screen for behavioral health issues and either address those issues within the primary care system, or arrange for a specialist referral, as appropriate, based on a member's needs. WellPoint State Sponsored Business will have representatives attend and participate on Magellan's Quality Improvement Committee and Magellan will have representatives attend and participate in our Quality Improvement Committee. This will allow both parties the opportunity to track and correct any quality issues on a parallel and coordinated basis. At meetings, Magellan will present core performance indicator data to benchmark, evaluate progress, and identify opportunities for improvement in four areas: access and availability, utilization management, member services, and network. Magellan is responsible for the full range of behavioral health organization activities, including network development and management, customer service, claims processing, utilization management, quality assurance, and care coordination (care management).	
Description of subcontractor payment: Our contract with Magellan is a capitated per member per month arrangement.	

Program: Nevada Medicaid and Check Up (SCHIP)	
Description of behavioral health services: The state of Nevada recently announced its intent to award WellPoint State Sponsored Business a contract for its Medicaid and Check Up (SCHIP) programs. We are currently developing a comprehensive network to provide behavioral health services to recipients and, in particular, ensure that our network has sufficient psychiatrists and/or psychologists to see the SED and SPMI patients. Our network will select providers who have demonstrated the aptitude and expertise necessary to satisfy the complex needs of the SED and SPMI membership. In addition, coordination with community agencies (e.g., schools, the legal system, group homes, and facilities) will be essential to positive health care outcomes for our SED and SPMI members. Services specific to our SED members can include treatment from community-based mental health counseling, home-based community intervention services, parenting education programs, partial hospital programs, day treatment programs, residential treatment centers, therapeutic foster home, or inpatient psychiatric services. Services specific to our SPMI members will include community-based services, vocational reinsertion programs, living skills orientation training, or inpatient psychiatric services.	
Total Population: 50,000 (anticipated enrollment)	**Serve SED / SPMI:** Yes.
Services provided by subcontract? Yes. This subcontract is under negotiation and cannot be revealed at this time.	
Description of subcontract arrangement / coordination of care across entities: The contract will provide for close coordination of care, periodic meetings, and other terms similar to other subcontract arrangements.	
Description of subcontractor payment: We anticipate an arrangement that pays the subcontractor on a capitated per member per month arrangement.	

2. Medical Management Model for Success

WellPoint State Sponsored Business is adept at developing a medical management model specifically tailored to the needs and requirements of each of our customers' individual programs.

Physicians and medical and behavioral practitioners are required by contract to provide communication and share relevant member information with each other on a timely basis. Examples include:

- a specialist consultant forwards a detailed report to the referring PCP;
- an attending psychiatrist forwards a psychiatric hospital discharge summary to the PCP;
- a medical practitioner provides a mental practitioner with member history, and physical and pharmacy regimen; and
- a physical therapist forwards PT progress reports to the PCP.

Core Model Activities

At the core of every winning program are certain key activities that are essential and aid in the success of that program. These coordination of care basics include:

- participation in monthly meetings between the physical health and behavioral health care managers,
- coordination of information between physical health and behavioral health providers, and
- participation in mutual studies.

Experience with Ethnically and Racially Diverse Populations

WellPoint State Sponsored Business has an extensive Cultural and Linguistics Program that addresses the specific needs of the members we serve, and includes working with providers to facilitate a culturally appropriate care environment. Specifically for use by our providers, we have introduced the successful Cultural & Linguistics Toolkit. This Toolkit is available on our Web site to educate physicians and office staff about interpreter services for our limited English proficiency (LEP) members. We emphasize bi-lingual skills in our Customer Care Center (CCC) to serve our members on phone calls, and when necessary we will use interpreter services for translation. Our interpreter services will also provide assistance during office visits and other health care events where language assistance is needed.

In California, our Medi-Cal members represent 11 prevalent languages. Our members also comprise a multitude of nationalities, including Hispanic, Asian, European, and Eastern European. Depending on the population and individual program requirements, we provide translated informational materials (e.g., the Evidence of Coverage/Member Handbook,

newsletters, popular health education materials, reminder postcards). To accommodate members who do not have English as a first language, we conduct a network search to locate appropriate language and skill-based professionals.

We want to stress that, at WellPoint, ethnically and racially diverse populations are not treated differently than the rest of the population. They have the same access and opportunity to receive the services available to the mainstream population. However, because cultural and language barriers to communication and understanding of health care issues exist, WellPoint State Sponsored Business takes special care to understand the needs of every population it serves.

3. Coordination of Care for the SED and SPMI Population

WBH provides a variety of behavioral health services in seven states. In business since 1990, WBH has more than 6.5 million members enrolled in our managed care and utilization review programs.

WellPoint State Sponsored Business is experienced in coordinating care for both the SED and SPMI populations using our in-house behavioral health experts at WellPoint Behavioral Health (WBH) and through the use of subcontractors. In either case, our members are cared for in a seamless manner as if they were receiving medical and behavioral health services from one health plan.

a. SED and SPMI Experience

WellPoint State Sponsored Business creates robust behavioral health networks aimed at servicing the needs of the SED and SPMI population. Our networks include providers that have demonstrated the aptitude and expertise necessary to satisfy the complex and unique needs of this membership. Included in our networks are psychiatrists and psychologists with a successful record of accomplishment in providing exceptional clinical care.

Our behavioral health benefit management department takes a comprehensive approach in determining the necessary services.

Coordination between community agencies (e.g., schools, the legal system, group homes, and facilities) is essential to positive health care outcomes for our SED and SPMI members. The purpose of offering comprehensive service coordination is to assist our members in achieving an adequate level of functionality within their community.

As part of this treatment philosophy, coordination of services must also extend to non-clinical needs. For example, it is common for this membership to fail to make appointments, or set appointments and not keep them due to life circumstances beyond their control. WellPoint State Sponsored Business provides outreach to such members by scheduling medical appointments for them and arranging their transportation when necessary. Our providers investigate other family and life circumstances in order to identify opportunities that may reduce obstacles to care.

Services Specific to our SED Members

- Treatment from **community-based mental health counseling** includes individual, family, and crisis intervention for children and their families to allow them to cope with their emotional, behavioral, or social difficulties.
- Community intervention that provides systemic services to children, families, and caregivers, known as **home-based community intervention services**, in their own environment, is crucial for long-term success.
- The family environment is critical to the well-being of a child. Parents or guardians may lack the resources, skills, or experience to cope with difficult circumstances. **Parenting education programs** provide support to caregivers, offering them the basic tools needed to care for their children and themselves. These tools include help for the parents to learn how to deal with their own circumstances as well as how to best cope with their children at home and maintain a stable environment for their family.
- Occasionally, members require more intensive structured programming. **Partial hospital programs** allow the members to interact with clinical staff and other individuals with similar issues when dealing with their own concerns. The comprehensive provision of individual counseling, group therapy, and instructional classes allows members to learn new skills and offers insight into their issues. At the end of the day, the members can go home and use their new coping strategies, with the comfort of knowing that they can return to the partial hospital program to fine-tune their results. In our networks, we include a variety of facilities and groups to ensure that we have the resources necessary to provide partial hospital programs for several weeks during a six to eight hour-program day for our members.
- Individuals with less complicated problems and greater insights or resources to cope with their issues often can benefit from a program of a shorter duration. **Day treatment programs** typically last from three to four hours and patients attend several days per week for up to several months. This program offers similar benefits to other structured programs, but with greater opportunity to test new coping skills due to less restricted treatment rigors.

- For patients in need of rehabilitative services, **residential treatment centers** provide a level of residential treatment in a structured, therapeutic, and medically supervised environment. At-risk children respond well to treatment in this environment, when other personal behaviors or environmental elements threaten their safety or treatment outcomes.
- When treatment is required in an out-of-home placement, without the need for medical supervision, a **therapeutic foster home** can best assist children with behavioral problems. Whether the source of a child's conflict is internally motivated or an effect of a difficult home life, a therapeutic foster home can provide a safe haven where professionals can implement therapeutic strategies without the restrictions of formalized programs.
- WellPoint State Sponsored Business provides **inpatient psychiatric services** when this level of service is warranted. For our network, we select general hospitals and freestanding psychiatric hospitals that have demonstrated quality programming. Since this level of service involves the most restrictive programs, we focus on active orientations toward discharge planning, patient follow-up, and family member involvement in treatment.

Services Specific to our SPMI Members

Adults often times find that the combinations of their own health concerns extend well beyond themselves. Adults must have the ability to manage family demands, occupational stress, and environmental distractions in order to promote positive health care outcomes. Collaboration with network providers who understand the interdependency of these health facets is critical. Each member must consider his/her problems in the context of the total demands of life. Our services to SPMI members include:

- **Community-based services** that provide individual and group modalities are one important link in the health care chain, but successful treatment for adults, similar to the treatment for children, must also take into account the severity of problems to achieve the best results. As with children, we would coordinate partial hospitalization, day treatment programs, and residential treatment programs when appropriate.
- We also provide other types of programs to ensure individual success. These include **vocational reinsertion programs** aimed at educating members on how to cope with their health demands while seeking an entry or return to productive employment. Structured programs aimed at preparing individuals to select and succeed in active employment are important in order for our patients to achieve a lasting solution to their life problems.
- As part of this self-education, many adults also require **living skills orientation training** aimed at learning the basic self-help skills needed to maintain a productive life. Program elements may include successful medication compliance instruction, adaptive behavior skills, healthy hygiene classes, and community living programs.

- As mentioned above, we provide **inpatient psychiatric services** when this level of service is warranted. We give first preference to programs with active orientations toward discharge planning, patient follow-up, and family member involvement in treatment.

In summary, a successful behavioral health network must include clinicians, professionals, paraprofessionals, and programs that always place the member's well-being first. WellPoint State Sponsored Business' behavioral health networks are comprehensive, but most importantly, built with compassion and understanding for our SED and SPMI members.

b. Behavioral Health Program Design Choices

An active management design is the most appropriate. We have preliminarily identified the following design choices to ensure the needs of the SED and SPMI population are met:

- Members of this population often need transportation to/from care. The plan needs coverage of these services to get the member the care they need.
- The plan needs to be able to coordinate wrap-around services.
- When managing outpatient services, the true key to success is to manage all facility-based services for this population. Specifically, post-discharge planning requires contractual agreements aimed at reintegration into the community.

c. Choosing to Carve-In/Out Behavioral Health Services

Our interest in bidding for the Middle Tennessee Region contract would not change; we are interested in proceeding further regardless of whether the SED and SPMI population is carved-in or carved-out. WellPoint State Sponsored Business can adapt to any level of coordination and service necessary to meet the needs of the Tennessee Medicaid population. In the event that TennCare carves out this population, WellPoint would want to understand how the population would be diagnosed and cared for and would want to have the opportunity to discuss with the responsible organization on a case-by-case, in accordance with need basis to ensure the members are placed in the proper programs and receive appropriate care.

d. Interest Level

Our response and interest level would not change.

4. Experience with Essential Community Providers

WellPoint State Sponsored Business has experienced positive results working with the essential community providers and community mental health agencies in the states of California, Virginia, and West Virginia.

When WellPoint State Sponsored Business builds a provider network, we proactively recruit essential community providers. In California's SCHIP, health plans with the largest number of essential community providers in their network are recognized. For 2005-2006, WellPoint State Sponsored Business has been designated as the plan in 98 percent of California's counties. To maintain existing providers and motivate new ones, we offer provider incentives as a reward for quality and a catalyst for network growth.

WellPoint State Sponsored Business uses safety net providers, including essential community providers, as the cornerstone of its networks. We have learned from our experience that essential community providers often are the medical home for our members. Federally Qualified Health Centers (FQHCs) focus on wellness and early prevention, a practice that WellPoint State Sponsored Business shares equally with the FQHCs. FQHCs are required to meet rigorous standards related to quality of care and services, which makes them ideal partners with WellPoint State Sponsored Business. Inclusion of essential community providers enables continuity of care and engages providers who have developed services that are responsive to the specific needs of our members. In certain areas, essential community providers may be the only providers able to deliver services to Medicaid and other under-served populations.

Essential community providers understand the challenges Medicaid, SCHIP, and other publicly funded members face, their issues regarding cultural and linguistic access to health care, and their need in many cases for referral to additional community resources.

WellPoint State Sponsored Business also is aware that the financial viability of essential community providers is integral to the broader health of the community. Essential community providers ensure access to care for both the Medicaid beneficiary and the medically indigent. Shifting revenue away from these providers may jeopardize their ability to serve as a safety net for persons with no resources, and prompt members who otherwise have no other alternative to seek primary care in an emergency room.

5. Behavioral Health Program Design and Financial Recommendations

WellPoint State Sponsored Business recommends that a requirement that fully integrates behavioral health care management with medical care management is included in your RFP. For a successful program, it is imperative that a designated behavioral health coordinator act as an intermediary between the medical staff, behavioral health staff, and behavioral health community resources.

Based on our experience, we found an invaluable opportunity when we collaborated with a state agency to conduct quarterly reviews of the behavioral health claims costs in comparison to the anticipated expenditures. When the level of utilization rose 3 percent above the anticipated costs and the appropriate level of care was being provided, the state agreed to implement an alternate payment schedule. The ongoing communication was a key factor in the success of this

financial stipulation and created opportunities to discuss other important program elements. The result is all went well and the state never had to adopt the alternate payment schedule.

B. PHARMACY SERVICES

WellPoint State Sponsored Business' approach to managing pharmaceutical costs has been to utilize our in-house Pharmacy Benefits Manager (PBM), WellPoint Pharmacy Management to provide therapeutically appropriate and cost effective drug therapy.

1. Approach to Pharmacy Carve-Out

Currently, WellPoint State Sponsored Business has access to a variety of formulary compliance, generic utilization, and cost containment strategies by using our wholly owned PBM to manage its pharmaceutical benefits for the California Medicaid program.

The Outpatient Prescription Formulary is our cornerstone in progressively managing the pharmacy benefit our unique members. Our Formulary promotes rational, scientific care based on consideration of published clinical studies, FDA data, community standards, and cost-benefit evaluations. Effective use of the Outpatient Prescription Formulary comes from the support of all of our providers (physicians and pharmacists). Our Pharmacy and Therapeutics Committee is composed of practicing physicians and pharmacists representing a wide variety of specialties. Our Committee meets regularly throughout the year to maintain and revise the Formulary as necessary. Access to the TennCare formulary and any changes would be required to effectively manage the formulary and optimize compliance to generics and formulary brands. Additionally, WellPoint State Sponsored Business needs to have information regarding any applicable pharmacy programs that may affect drug trend (i.e. list of drugs requiring prior authorization of benefits), specialty pharmacy distribution channels and coverage, etc.

If TennCare intends to continue with the current PBM contract and carve-out pharmacy services, WellPoint State Sponsored Business will work and expect similar reports from TennCare's PBM, First Health, including:

- Performance Reports — prescription drug performance, physician performance, group performance, generic savings, therapeutic detail profile, distribution of claims, age/sex (5-year, HEDIS or custom banding), and disease state summary
- Drug Utilization Reports — top therapeutic class, subclass and composition; smart key (therapeutic classes, subclasses, and composition); top generic code; top drugs, non-formulary drugs, high cost drugs, physicians, pharmacies, pharmacy chains, and patient utilization; claims detail; dispense as written summary; market share; and claims download
- Standard Reports Package — financial summary; financial lag; performance summary, therapeutic classes, subclasses, composition, and class detail; pharmacological class report; patients by amount paid; and top physicians by specialty

- Drug Utilization Reports — for specialty drugs, compounded medications and over the counter drugs

With these similar reports from TennCare's PBM, WellPoint State Sponsored Business will use pharmacy data to identify individuals who would benefit by participation in the following WellPoint State Sponsored Business programs:

- Care Management program — increases compliance to medication regimens and follow-up with appropriate specialists or primary care physician
- Disease Management programs (i.e., asthma, congestive heart failure, diabetes) — decreases hospitalizations, increases quality of life, decreases ER visits.
- Members-at-Risk program — a program where case managers work with members who have been identified in a pharmacy report as having poly-pharmacy issues. This program decreases inappropriate emergency room utilization and increases member referrals to appropriate services (e.g., pain management programs, chemical dependency programs).

Pharmacy data may be incorporated in the Physician Profile Reports, if this data is not already made available to prescribers by First Health.

2. Pharmacy "Real-Time" Information

WellPoint State Sponsored Business would require the pharmacy data to be transmitted in a usable format to our in-house PBM, WellPoint Pharmacy Management, on at least a monthly basis. By having this pharmacy data on a monthly basis, WellPoint State Sponsored Business would have current drug usage, prescription fills/refills, and contraindication information. This information would provide our Care Management and Disease Management departments the necessary data to educate providers, identify and monitor outlier prescribers and users, and coordinate prescriptions across providers.

If TennCare decides to carve-in the pharmacy benefits, WellPoint State Sponsor Business would have access to true "real time" pharmacy data. Our in-house PBM transmits pharmacy data every 10 minutes and keeps our plan informed of drug usage, prescription fills and refills, and contraindications. With true "real time" pharmacy data, WellPoint State Sponsored Business will be able to provide the best care for our members and control both medical and pharmacy costs.

Recommendation for Pharmacy Services

WellPoint State Sponsored Business recommends that the state of Tennessee carve-in the pharmacy services to the managed care health plan. With our robust data reporting capabilities, we have found that we can provide better management of pharmaceutical care for our members. Our wholly owned PBM would allow our plan to implement various clinical intervention programs listed below:

- Senior Awareness Response Program identifies poly-pharmacy activity and potential adverse drug event
- Member Awareness Response Program identifies and shares with physicians high patterns of drug utilization by members, which may lead to drug misadventures and/or fraudulent prescription drug purchases
- Depression Disease Management Program addresses issues surrounding under treatment and excessive resource utilization in depression
- Asthma Consultation Program increase adherences to asthmatic medication for positive health outcomes

Our reporting abilities and staff expertise allow for better control of the pharmacy benefit utilization, which promotes the affordability and management of pharmaceutical care.

C. Long-Term Care Services

The following paragraphs describe our methods and procedures for coordinating acute and long-term care between providers and plans. We also describe our philosophy on providing the best care for our members and the reasoning behind providing those services.

1. Coordinating Care

State Sponsored Business' Care Coordination is a specialized care management service designed to ensure that all members receive appropriate medically necessary and quality health care services. Care coordination includes, but is not limited to:

- identification of needs — including physical health, mental health services, and long term support services;
- coordination of a care plan to address those needs;
- assistance to ensure timely and coordinated access to an array of providers and services;
- attention to addressing unique needs of members; and
- coordination of Health Plan services with social and other services delivered outside the Plan, as necessary and appropriate.

The member or member's responsible party is always involved in evaluating options and making health care decisions, and that has been key in successful outcomes.

The medical management system allows for real-time communication between Preauthorization, Concurrent Review, Care Management, Health Services and Claims, thus preventing duplicative services and reducing gaps in services. At any time, medical management staff can view a member's history, current and previous services, paid claims, authorizations and other related services. Concurrent Review, using industry standard triggers,

can refer a case to Care Management. While the case manager and the concurrent review nurse collaborate with attending physicians on a member's discharge plan, the case manager can also refer the member to Health Services for participation in health classes or for educational materials…all electronically on the shared system.

For members receiving long-term care services, frequent communication is made between case managers and community based caregivers in order to appropriately authorize needed services. All information is documented in the system. Finally, case managers are responsible for ensuring the coordination of care for their members until case closure is documented with member outcomes recorded.

2. Incentives

WellPoint State Sponsored Business always strives to get the member from hospital to home as quickly as possible for the member's benefit. Most members prefer to be in familiar territory, possibly with family, rather than in a strange environment such as a hospital, especially when they are recuperating from an illness. However, we also balance this goal with the member's need to receive the appropriate care in the appropriate setting.

We recommend an incentive in the managed care organization (MCO) contract that would reward the MCO when it achieves diagnosis-based cost savings using home and community-based services. For example, the incentive may be based on the cost savings difference between the potential cost of hospital care usage and the actual cost of care in a less-expensive environment. These environments may include short-term stays in a skilled nursing facility, adult foster care, community-based, or home health services. The percentage of cost savings and other parameters of the incentives would be agreed upon by the Bureau of TennCare and the contracting plan prior to implementation. Both parties on a periodic basis should review the target savings and incentive.

D. EPSDT Services and Incentives

Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) are an important step in determining physical or mental conditions in recipients under age 21. WellPoint State Sponsored Business commends the Bureau of TennCare on its focused efforts to enhance EPSDT rates and compliance with the periodicity schedule.

1. Approach to EPSDT Services

State Sponsored Business' EPSDT program aims to motivate our young members to establish good health habits that will last a lifetime. We have operated EPSDT programs in other states for almost a dozen years, educating providers through training seminars, and offering provider offices tools to implement reminder systems and track missed appointments. We use various communication approaches to inform members about benefits and services that meet their

individual needs. We notify members of the need for an initial health screen (IHS) and follow-up to ensure that as many members as possible receive an IHS and are assessed for potential health risk. IHS information is included in the new member packet, member newsletters, and Web site information. In addition, we send our eligible members monthly well-visit reminders to reiterate the importance of regular check-ups. Within 10 days of enrollment, we send the enrollees an informational packet and a description of the EPSDT program.

We tailor our outreach efforts to ensure that all eligible children receive services according to the periodicity schedule. We are fully aware of the need to target expanded outreach efforts, such as telephone calls, to members who will require extra assistance, rather than engaging in unfocused, "one size fits all" outreach activities. We encourage members to select a PCP and have their IHS within the prescribed time frames through reminder notices and/or direct member contacts. Our Customer Care Center (CCC) representatives are also available to assist members in understanding the need for preventive services and how to access their PCP. Members may contact our CCC for additional information or support.

In addition, we coordinate with PCPs to ensure that members' parents or guardians schedule appointments when the members are out of compliance with the periodicity schedule. We post on the provider Web site a monthly list of members who do not receive services within 90 days of enrollment. The notice engages PCPs in a continuing effort to ensure members obtain preventive care services. We work with providers to contact their new and established members to make an appointment for an IHS, immunizations, and regular preventive care.

Physician Incentive Programs

State Sponsored Business has redesigned our bonus program for 2006 to align physician incentives around quality of care measurements. We have created a methodology to overcome the small panel sizes and small sample sizes for individual measures that have presented major barriers in the creation of pay for performance programs in Medicaid. Our methodology pools physician behavior across a number of measures and looks at how often the physician "did the right thing" when presented with an opportunity to improve care. The measures chosen reflect a combination of preventive health measures and chronic disease management measures (e.g., well-child and well-adolescent visits, LDL (cholesterol screenings), and diabetes, cervical cancer, retinal, and asthma exams). Each of the individual measures represents an opportunity to provide preventive care. The total number of preventive services divided by the total opportunities determines the overall composite score. Physicians are assessed on their percentile ranking within their specialty.

Recommendations for MCO Incentives

WellPoint State Sponsored Business is committed to the importance of increasing EPSDT screening rates, and we are open to exploring incentives. We applaud the Bureau of TennCare for providing an incentive for this important preventive benefit. As an adjunct incentive, perhaps the state of Tennessee would consider an annual reward of assigning a higher percentage of auto-assigned members to the MCO with the greater EPSDT rate increase in the past calendar year.

E. Utilization Management / Medical Management

WellPoint State Sponsored Business' Utilization Management (UM) Program is an ongoing and comprehensive program that establishes a formal process for developing, implementing, and continuously evaluating effective UM processes.

Our program objectively monitors and evaluates the efficiency, appropriateness, and quality within all aspects of our care delivery systems. It is designed to facilitate the delivery of medically necessary health care to members while promoting optimal clinical and cost-effective outcomes.

1. Experience with Benefit Limits and Prior Authorization

WellPoint State Sponsored Business is experienced with a hard benefit limits in our statewide California Medi-Cal program, which serves 865,000 members. In this program, members have a six-script limit, with additional scripts requiring prior authorization. A hard benefit limit is a cost-savings, but more importantly addresses an important safety issue — implementing a prior authorization after six scripts decreases the likelihood of an adverse drug interaction when a member has a high number of multiple prescriptions. The following section describes our experience with managing care with benefit limits and our proven prior authorization process.

Benefit Limits

WellPoint State Sponsored Business Medical Management has extensive experience in administering plans with benefit limits. Some of our programs have both hard and soft limits and we have processes in place to manage the cost by improving quality of care. These programs have allowed State Sponsored Business to provide services over the limits when deemed cost effective by the plan. We employ a number of approaches to effectively manage these benefits such as requiring prior authorization, substitution of benefits, proactive discharge planning, care management and providing health education services. We collaborate with our members, their representative, and as appropriate, their physician, and review with our members all medically appropriate alternatives available to them. We also will serve as a resource to the community by linking members and providers to government and community agencies and resources, both network and out-of-network providers.

State Sponsored Business will utilize the same process for the Bureau of TennCare program. Our clinical staff will review the medical appropriateness of allowing additional benefits and will assess the health outcome from these benefits, thus avoiding costly medical services in the future.

The following are examples of how State Sponsored Business has managed benefit limits.

- One of our programs covers hospitalization but does not cover a stay in a skilled nursing facility or home health services. We have found that the best approach, in conjunction with the prior authorization process and our member's cooperation, is to review the needs of our members on a case-by-case basis and provide the best services available. The process includes a thorough discharge plan, moving the inpatient to a skilled nursing facility or home-based care setting, if appropriate care can be maintained and the same outcome can be reached while at the same time controlling costs.
- Our experience in working with a variety of publicly funded programs has shown us that coverage of services is very limited at times. For example, coverage allows for an eye exam, but not the cost of glasses. Or, the member is unable to walk and requires a wheelchair but the plan does not cover the costs of durable medical equipment. When we find a member in this situation, we turn to services provided by community-based organizations. WellPoint State Sponsored Business has become adept at finding partners in the community that provide what the individual needs – for example, an organization that will help with the cost of eyewear, or a charitable organization that donates a wheelchair. WellPoint State Sponsored Business has built valuable relationships in many communities with these voluntary services and community-based and charitable organizations.

Other examples:

- Inpatient benefit limit: 15 days per calendar year (hard limit). Required authorization for any inpatient admission and the UM Department makes the determination for appropriate length of stay and appropriate setting based on approved criteria and the member's condition. By requiring authorization, State Sponsored Business is able to identify members who may benefit from case management and also find an alternative setting to help save their benefits. We also substitute outpatient to inpatient days in this situation.
- Physical therapy limit: Limited to 24 visits and visits exceeding the limit require authorization (soft limit). The UM Department reviews the medical appropriateness of physical therapy after members reach the limit. Additional physical therapy may prevent a surgical procedure, which is beneficial for the member, and at the same time reduce costs. The system also is programmed to allow the first 24 visits and checks for authorization in excess of 24 physical therapy visits.
- Pharmacy limits: WPM's pharmacy prior authorization process interacts with Medical Management for either drugs with quantity limits or drugs that are limited to use for

specific conditions. These drugs have specific system identification (edits) and when members present to the pharmacy, the prescribing physician is contacted with instruction to call WPM's Prior Authorization (PA) Center. When the PA Center cannot approve the drug, the PA Center sends the request electronically to Medical Management for review. The request is reviewed using approved guidelines and when necessary, a physician is consulted to review for appropriateness.

Decision and Screening Criteria

WellPoint State Sponsored Business applies the following criteria for utilization management screening and decisions in accordance with the member's specific benefit plan:

- Milliman Care Guidelines
- WellPoint Medical Policy and Clinical Guidelines

Decision and screening criteria assist UM program associates in assessing the appropriateness of care and length of stay for clinical or behavioral health situations encountered most frequently in regular practice. Application of the criteria is not absolute; it is based on a member's specific health care needs and benefit plan, as well as the capability of the health care delivery systems. We can make the criteria available to a member or provider upon request through our UM Department.

Decision criteria incorporate nationally recognized standards of care and practice including those outlined by the American College of Cardiology (ACC), the American College of Obstetricians and Gynecologists (ACOG), the American Academy of Pediatrics (AAP), the American Academy of Orthopedic Surgeons, current professional literature, and cumulative professional expertise and experience. The decision criteria used by our UM clinical reviewers are evidence-based and consensus driven. We update our criteria as standards of practice or technology change.

2. UM / MM Recommendations

WellPoint State Sponsored Business recommends the following UM / MM practices to the state of Tennessee for its Medicaid Managed Care program:

1. Apply benefit limits to non-emergent transportation.
2. Eliminate chiropractic benefits.
3. Limit occupational therapy / physical therapy / speech therapy to 24 visits per calendar year (May consider applying soft limits to physical therapy if it will lead to a better outcome and is determined to be cost-effective by the MCO. (i.e., when additional physical therapy will prevent surgery).
4. Limit outpatient mental health visits to 20 per calendar year.

5. Mandatory generic drug prescriptions.
6. No limits on preventive care services for all members. Setting limits could lead to more costly service(s) further into the member's care.
7. Allow for a broad substitution of benefits in the program as long as the member continues to receive the appropriate level of care with the same assumed outcome.

   As an example of substitution of benefits, we refer to a member that required hospitalization and post-surgery recovery. As noted previously, the program does not cover stays in a skilled nursing facility or home health services. To complicate matters further, this member is homeless. The choice came down to continuing unnecessary hospitalization or releasing the member back to the streets. WellPoint State Sponsored Business substituted the cost of a continued hospital stay with a cost-saving move to a skilled nursing facility for recovery only. This substitution of benefits resulted in a win-win situation for everyone impacted by the homeless member's situation.

F. DISEASE MANAGEMENT

Disease management programs are an important component of the medical operation management services of WellPoint State Sponsored Business. In the last six years, industry leaders, including the Blue Cross Blue Shield Association and America's Health Insurance Plans, have honored WellPoint State Sponsored Business with eight awards for its disease management and member care programs.

Physical Health

We tailor existing programs to the needs of a new population, monitor outcomes, and track trends. We will design new programs (i.e., for coronary artery disease and chronic obstructive pulmonary disease) if our assessment indicates a need for such programs and we determine that members would benefit from these programs. Our Health Services staff members have numerous years of professional experience in developing disease management programs for various populations. We would not, at this time, make recommendations as to specific disease management programs that should be run in the Middle Tennessee Region. Rather, after contract we would analyze data, evaluate your population, and then determine which programs would best serve your Medicaid members.

1. Disease Management Programs

WellPoint State Sponsored Business currently operates disease management programs in the areas of diabetes, asthma and high-risk obstetrics. Table 11.F-1 identifies, by state contract, our formal disease management programs currently in use.

Table 11.F-1: Disease Management Programs by State and Contract

State Contract	Disease Management Program
California Department of Health Services / Medi-Cal (Medicaid Managed Care)	Asthma Diabetes High-risk obstetrics
California LACare / Medi-Cal (Medicaid Managed Care)	Asthma Diabetes High-risk obstetrics
California Healthy Families (SCHIP) Program	Asthma High-risk obstetrics
Virginia Department of Medical Assistance (DMAS) / Medallion II Medicaid Managed Care	Asthma Diabetes High-risk obstetrics
Virginia DMAS / FAMIS (SCHIP)	Asthma Diabetes High-risk obstetrics
West Virginia Bureau for Medical Services (BMS) / Medicaid Managed Care	Asthma Diabetes High-risk obstetrics

WellPoint State Sponsored Business' disease management programs include member education materials and outreach interventions to educate our members on their health care needs. We also collaborate with our physicians in treating our members by providing clinical tools and information that they can use in treating our members. The following are health education and promotion programs that also support our disease management programs:

- Prenatal
- Get Up and Get Moving (Obesity program for children)
- The Last Cigarette (Smoking cessation program for pregnant members)
- Member Rewards (promoting well-child visits and immunization)
- Well Woman (mammography, cervical cancer, and Chlamydia screening)

2. Functions and Responsibilities of the Disease Management Programs

WellPoint State Sponsored Business fully performs and executes our disease management and health education programs.

3. Approach to Disease Management

Based on medical and pharmacy utilization, WellPoint State Sponsored Business has developed a comprehensive algorithm to actively identify and risk-stratify our members for each disease management program. Upon identification, we enter members' names into a disease-specific program database registry to monitor management of each member's disease condition, and apply interventions accordingly. We base the type and intensity of intervention(s) a member

receives upon the member's risk stratification within the disease management program. High-risk members typically are the highest cost members in terms of medical utilization (e.g., inpatient stays and emergency room visits related to their disease condition) and they receive our program's full scope of interventions. We identify members through a condition-specific claims data sweep. Interventions target members proactively to prevent escalation to higher risk levels. .

Each disease management program typically provides members with disease-specific education materials; making Web-based tools available; conducting outreach phone calls for higher risk members; and sending out appointment reminders for recommended screenings and/or tests for specific conditions. Our disease management programs are based on the recommendations of the most current clinical practice guidelines developed by the National Heart, Lung, Blood Institute for asthma care, the American Diabetes Association for diabetes care, and the American Heart Association for cardiac care. Our clinical guidelines and program materials are available on our provider Web site. Each year, we fax information to the PCPs to update them of their assigned members' disease state and management process.

WellPoint State Sponsored Business serves many members in its disease management programs. Annually, the programs serve approximately:

- 45,000 Asthma Medicaid Managed Care and Healthy Families (SCHIP) members
- 18,000 Diabetes Medicaid Managed Care members
- 17,000 Prenatal Medicaid Managed Care, Healthy Families (SCHIP) and AIM members

WellPoint State Sponsored Business' disease management programs are implemented and managed by highly qualified and highly educated staff, many of whom hold advanced degrees and are experienced specialists in their field of practice. Table 11.F-2 provides a brief summary of our key personnel responsible for development, oversight, and support of our disease management programs.

Table 11.F-2: Disease Management Program Key Personnel Summary

Title	Degree	Role
Vice President, Medical Operations	R.N., B.S.N.	Senior Management support and oversight
Medical Directors	M.D.	Program development, medical oversight for clinical validity and program-specific physician champion
Director, Health Services	M.P.H.	Program development and oversight
Director, Medical Operations	R.N., M.P.A.	Clinical oversight, program development and support
Senior Health Services Analyst	M.H.A.	Program development, management and evaluation
Senior Health Education Specialists	B.S. and/or M.P.H.	Program development and management
Senior Health Promotion Specialists	M.P.H.	Program implementation and member & provider support
Nurse Care Management Staff	R.N.	Clinical case management
Social Care Management Staff	B.S.W.	Social case management
Senior Health Services Analyst	M.S.	Systems programming and analysis
Senior Health Care Reporting Analyst	B.A.	Program database development and data reporting

Through our extensive experience in developing, implementing, and continuously improving our disease management programs, we have gained insight into effective strategies to overcome barriers to care. Using our experience, we are able provide our members with the critical care coordination, health education, and support they need to effectively manage their disease states within the context of their benefits.

In addition to the aforementioned disease management programs, WellPoint State Sponsored Business has developed innovative obesity/weight management, tobacco cessation, and prenatal programs. These programs address the overriding issues affecting health care and health management and at the same time, the member and provider interventions we have developed assist our members in managing these conditions.

Behavioral Health

WellPoint State Sponsored Business and our in-house experts, WBH understand that behavioral health is an important issue for the Bureau of TennCare and its members. We understand that equally important is the care management and coordination of care that Bureau of TennCare members will receive under the reform program. We would design a program that meets, if not exceeds, your population's needs — offering care management and targeted interventions for schizophrenia, bipolar disorder, major depression, and co-occurring mental illness/substance abuse conditions.

4. Care Management Program – Behavioral Health Conditions

Our WBH care management program provides for these conditions for all lines of business across the country, in both our publicly funded and commercial programs. These states include California, Georgia, and Missouri.

5. Behavioral Health Care Management Function

When we utilize WBH, we fully perform our behavioral health care management within our organization. When we use a subcontractor for behavioral health services, we execute day-to-day operations in much the same manner as with WBH. We maintain open lines of communication, hold periodic care management staff meetings to discuss interventions and unique care management events, facilitate the communications and documentation between providers, and identify find studies in which we can mutually participate.

6. Care Management Approach to Behavioral Health

The delivery of mental health and substance abuse services to the Tennessee Medicaid population will focus on quality of care, ensuring that we authorize the appropriate level of service and provide services in the appropriate facility or office. Our emphasis will be on providing quality care, not denying care.

The care manager will be a licensed behavioral health care practitioner, (e.g., licensed clinical social worker, licensed professional counselor, or psychiatric nurse) responsible for collecting the clinical information required to make medical necessity determinations.

All care managers have specialized training and handle calls from members requiring behavioral health services. Managing care with benefit limitations require the attention to detail regarding meeting the member's current needs with an eye to the potential needs for services during the rest of the benefit year. Serving as stewards of the member's benefits means not only authorizing care at the present, but also closely coordinating the care with the member's provider to ensure that benefits will remain available to the member throughout the year. Care managers will have the authority to approve treatment services but not to deny them. Only a peer of the requesting provider can issue denials. If a psychiatrist is requesting care, a psychiatrist reviewer will make the determination regarding appropriateness of care.

All behavioral health and substance abuse care is based on medical necessity, which is defined as procedures, supplies, equipment, or services that are determined to be:

- Appropriate for the symptoms, diagnosis, or treatment of a medical condition
- Provided for the diagnosis or direct care and treatment of a medical condition
- Consistent with the standards of good medical practice within the organized medical community

- Not primarily for the convenience of the patient's physician or another provider
- The most appropriate procedure, supply, equipment, or service that we can safely provide

Medical necessity criteria are the guidelines used by our utilization review and care management staff. While the criteria most often will determine the safest and most effective level of care, a small number of cases may fall beyond our staff members' scope. Thorough and careful review of each case, including consultation with supervising clinicians, will identify these exceptions. Clinical judgment consistent with the standards of good medical practice will be used to resolve exceptional cases.

We do not differentiate the management of specific psychiatric disorders, such as schizophrenia, bipolar disorders and major depression. We authorize care based on the needs of the member and the behaviors demonstrated by the member. The safety of members, their families, and the public at large is of utmost importance to us. Determination of appropriate services will first and foremost address safety needs.

Authorization and referral services will be available 24 hours a day, 7 days a week.

We identify members who require specific care management services in a variety of ways through triggers in claims systems; provider request; member request; and identification during the delivery of behavioral health services. Care management involves direct contact between the care manager and the member addressing compliance with medication therapy; regular attendance at appointments; identification of support systems for the member; and, the appropriate use of benefits as well as coordination with direct care providers.

Persons with both mental health and substance abuse diagnoses pose particular challenges for treatment. Initially, services will focus on the primary presenting symptoms relative to urgent or emergent treatment. We will address safety needs first. If a dually diagnosed member requiring inpatient treatment is suicidal, the safety issues will be addressed and resolved prior to addressing the member's chemical dependency needs. However, if a member requires detoxification from a chemical and is in medical danger, the chemical dependency issue will be addressed initially. The care manager will address both issues in the criteria set and if necessary, prioritize treatment with the provider and the physician reviewer. Many behavioral health treatment centers have special programs for dually diagnosed members that can address both mental health and chemical dependency issues concurrently. Our care managers will work with members to identify the providers who are most capable of meeting their identified needs.

G. CAPITATION MODEL

WellPoint State Sponsored Business has substantial capitated managed care experience to use as a foundation for future business.

1. Risk Experience

Since our entry into Medicaid business in 1994, WellPoint State Sponsored Business has been conducting Medicaid business almost exclusively under full-risk contracting arrangements. These arrangements rely on the accuracy and "actuarial soundness" of the capitation rates provided to health plans by the state. It is customary for us to evaluate the rate-setting methodology used by states to determine if their rates are actuarially sound and allow an adequate margin for us to prudently conduct business and add to reserves. We recommend that the state of Tennessee provide its rates and rate-setting methodology information to all health plans interested in bidding and establish a process to solicit feedback from the health plans.

2. Full-Risk Capitation Environment

A full-risk capitation environment in and of itself would not discourage our participation. We will base our participation on a decision-making process that includes an analysis of the long term projected profitability of the program, rates and your rate-setting methodology, the state's business environment, the regulatory environment, barriers to entry, and estimated membership potential.

3. Other Risk Options

We do not object to a full-risk arrangement, however, we are willing to consider alternatives including the mechanisms you have described for certain populations or certain services if they benefit both parties (e.g., stop loss on transplants, premature newborns, or lengthy inpatient stays). We would require more information regarding your utilization experience to determine if pursuing other alternatives is in the best interest of both parties.

4. Minimum Number of Covered Lives

Our participation will depend on a reasonable expectation of market share. Based on our cost of entry, we will require a minimum membership of 35,000. According to our estimate of lives in the Middle Region, the probability of meeting this minimum criterion is high. However, a mechanism to ensure minimum membership may be advisable and may take the form of a preferential default assignment algorithm if a plan falls below a minimum threshold.

Clarification of Counties in the Middle Tennessee Region

As of the morning of December 2, the list of counties by region on the Bureau of TennCare listed 39 counties in the Middle Tennessee Region. The list provided with the due date extension lists 38 counties –missing Perry County. Because Perry County borders the West Tennessee Region, the switch to another region is a possibility. We would appreciate clarification — specifically how this affects the total population in the Middle Tennessee Region — if the Bureau of TennCare has moved Perry County out of the Middle Tennessee Region.

H. Data and Systems Capability

WellPoint State Sponsored Business has developed extensive capacity to obtain and provide data and reports to our state customers, and to use data for our program monitoring and quality assurance activities. We have a proven, robust data system that we use to collect, track, analyze, and report data. Our system is flexible and adaptable to each customer's specific needs.

1. Data and Reporting Experience

WellPoint State Sponsored Business has a proven track record of compliant, timely, and accurate reporting on a periodic or ad hoc basis. We also have a dedicated reporting staff and sophisticated systems to ensure compliance with our customers' requirements. Table 11.H–1 summarizes the financial, enrollment, claims, utilization, quality assurance, provider network, member services, grievances and appeals, fraud and abuse, and other required reports that we currently provide to our Medicaid/SCHIP customers in California, Virginia, and West Virginia. We believe that the depth of our expertise and knowledge can readily support Tennessee's reporting requirements. In particular, we submit encounter data, representing 100 percent of claims data received, to all of our public clients, including the states of California and Virginia. We submit more than 1.8 million HIPAA-compliant medical institutional and professional encounters annually, as well as more than 4 million encounters annually in proprietary formats required by other state customers.

Table 11.H-1: State Sponsored Business' Experience with External Reports

Reports	Description of Data
Financial	Annual certified financial statements; quarterly financial reports; monthly financial statements; reports on cost avoidance and third-party recovery activities
Enrollment	Reports include data fields such as add family, terminate, change, re-enroll, reinstate, new coverage, and add member
Encounters	Encounter data submissions
Claims	Claims reports including claim turnaround times, total claims, total claim dollars, aged claims report, and bypass of edits; claim error rates (frequency and dollars); catastrophic claims showing diagnostic and procedure codes, total allowable charges, and total paid claims for each member
Utilization	Reports summarizing inpatient utilization, emergency room visits, and outpatient utilization (including admits, days, ER visits, average length of stay (ALOS), admits/1000, days/1000, ER visits/1000); prior authorization requests made, approved, and denied
Quality Assurance	Quality Improvement annual report, external quality review performance measures, Quality Improvement Committee meeting minutes, facility site review data, HEDIS, CAHPS member surveys, sentinel event reporting
Provider Network	Size, composition, and adequacy of provider networks (e.g., ratio of PCPs to members, PCP and specialist geographic distribution and percent of members within mileage threshold); and health plan subcontractors reports
Member Services	Reports on customer service responsiveness, including telephone response time, call abandonment rate, and number of inquiries made by type (e.g., access issue, claims adjustment, confirm eligibility.)

Reports	Description of Data
Grievances and Appeals	Grievance log and quarterly grievance report; administrative grievances (appointment availability and office wait times for routine/regular appointments, urgent care, and after hours)
Fraud and Abuse	Reports on activities to reduce fraud and recover expenditures (cases opened and closed, total open cases, letters sent, cases reviewed, providers terminated, recoupment dollars, special claims review, referrals, and appeals)
Other	EPSDT; children with special health care needs; marketing plan; reports on memoranda of understanding (MOU) with local health agencies

2. Methods of Monitoring, Measuring, and Evaluating Performance

WellPoint State Sponsored Business is well versed in working with customer requirements to monitor and measure quality improvement of care. We would use our experience in this arena to work with the Bureau of TennCare on aligning our Quality Improvement Work Plan with your needs and requirements. Our goal in every state that we enter is not only to meet but also to exceed our customer's expectations. Receiving a National Committee for Quality Assurance (NCQA) "excellent" accreditation is a testament to our success.

WellPoint State Sponsored Business relies on a strong, continuous quality improvement process to provide monitoring, measurements, and service oversight. We ensure accessibility and availability to appropriate health care, structure and operations, and quality measurement and improvement. We have collaborated with other state agencies and their External Quality Review Organizations (EQROs) in quality monitoring and evaluation activities, and are fully prepared to participate in EQRO activities as assigned and required by the Bureau of TennCare.

WellPoint State Sponsored Business documents the quality of care delivered to members by collecting and reporting HEDIS measures consistent with NCQA- and CMS-recognized methodologies and time frames. We use NCQA Medicaid benchmarks to establish our benchmarks for each measure. We set annual improvement goals based on study results. We collect HEDIS and other relevant study data using hybrid and administrative methodologies. The study methodology may also use administrative data (such as claims for initial health examinations or assessments and ER visits), pharmacy data (for diseases such as asthma), and pharmacy and laboratory data (for diabetes). In our NCQA-accredited programs, WellPoint State Sponsored Business contracts with a certified NCQA audit firm for HEDIS studies.

We use annual satisfaction surveys to collect comments, feedback, and complaints from members and providers in order to continually improve and enhance the effectiveness of our UM program. We review the satisfaction results at least annually for trends related to specific UM activities and the impact these activities have on members and providers. If we identify an area of dissatisfaction, we develop, implement, and evaluate interventions to determine that the corrective actions taken are successful. Focused quality improvement initiatives within the UM program often reflect this feedback and we ensure monitoring is in place for ongoing improvement. Our surveys cover all of our services so we are able to collect and provide

feedback on subcontractor services as well. Data that we use to monitor, measure, and evaluate our performance includes:

- Consumer Assessment of Health Plans Study® (CAHPS®)
- WellPoint State Sponsored Business' comprehensive analysis of each of its plans
- WellPoint State Sponsored Business' "Secret Patient Shopper"

I. Net Worth and Restricted Deposit Requirements

WellPoint is familiar with your net worth and restricted deposit requirements. These are similar to the requirements in other states in which we operate. WellPoint would be able to meet or exceed the net worth and statutory deposit requirements.

J. Implementation Time frame

The Bureau of TennCare has identified an aggressive yet achievable schedule for implementation of a competitive bid MCO program for the state's Middle Tennessee Region.

1. Time frame

The time frame does not impact WellPoint State Sponsored Business' decision to participate in the procurement process.

2. Procurement and Implementation Recommendations

State Sponsored Business makes the following additional recommendations for the Middle Tennessee Region Request for Proposal:

1. Six months is the minimum amount of time for a successful implementation. The optimal time frame is nine months.

   In order to successfully implement a program, we recommend that the Bureau of TennCare consider the cost-saving steps the state of Nevada took in its recent procurement process. The state of Nevada required only a work plan and approach to building a network, leaving the MCOs to contract with the providers post-award. Such an approach has a number of advantages: Providers will focus on contracting with two MCOs and not be "bombarded" by multiple plans vying for their attention; the state of Tennessee can save its potential health partners network-building costs during the procurement period; and this allows MCOs the necessary time post-award to build a comprehensive network.

2. MCOs would appreciate the state providing a tentative timeline for a readiness review during the proposal period in order to assist prospective partners in securing the necessary resources and capital required to support implementation efforts.

3. NCQA accreditation must be a definite requirement of the RFP. The state of Tennessee should not allow the substitution of lesser accreditations and must insist that a bidding health plan be NCQA-accredited as a Medicaid Managed Care program in at least one other state. As an independent organization that evaluates and measures the performance of health plans, NCQA is invaluable to public agencies such as the Bureau of TennCare. When a health plan agrees to NCQA accreditation, its books are opened for ongoing analysis and audit, and the plan agrees to the public release of NCQA's findings. Its findings serve as an incentive for improvement and the state of Tennessee can use the NCQA process as a yardstick to gauge performance and a catalyst for change.
4. Score financial stability / capability instead of evaluating as a pass / fail rating, this will ensure that selected health plans have the requisite financial solvency.
5. The Bureau of TennCare should not ask for cost proposals. Rather, the Bureau of TennCare should develop and set rates using an independent actuary. The Bureau of TennCare should provide the rate-setting methodology and databook to all MCOs interested in bidding, and allow an opportunity for comment on the rates during the procurement process. This allows the state to choose MCOs using a qualification based selection (QBS) criteria — selecting MCOs that can provide the best quality of care and service at rates that both the Bureau of TennCare and MCO agree are actuarially sound. MCOs attempting to win work by proposing a low cost bid may put the MCO at financial risk, forcing the MCO to return to the Bureau of TennCare looking for an alternate payment schedule. The goals of the Middle Tennessee Region Reformed Model, including improving the quality of care to beneficiaries and increasing the stability of MCOs, are not served by requesting cost proposals. Further, it would be appreciated if the Bureau of TennCare would review and gain input from the contracted MCOs during the annual rate increase process.
6. Require health plans to describe their experience in implementing provider networks in new areas.

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